A recorded vote was ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 233, noes 188, not voting 12, as follows:

[Roll No. 411]

AYES—233

Abraham
Aderholt
Allen
Amash
Amodei
Arrington
Babin
Bacon
Banks (IN)
Barletta
Barr
Barton
Bergman
Biggs
Bilirakis
Bishop (MI)
Bishop (UT)
Black
Blackburn
Blum
Bost
Brady (TX)
Brat
Bridenstine
Brooks (IN)
Buchanan
Buck
Bucshon
Budd
Burgess
Byrne
Calvert
Carter (GA)
Carter (TX)
Chabot
Cheney
Coffman
Cole
Collins (GA)
Collins (NY)
Comer
Comstock
Conaway
Cook
Cramer
Crawford
Culberson
Curbelo (FL)
Davidson
Davis, Rodney
Denham
Dent
DeSantis
DesJarlais
Diaz-Balart
Donovan
Duffy
Duncan (SC)
Duncan (TN)
Dunn
Emmer
Estes (KS)
Farenthold
Faso
Ferguson
Fitzpatrick
Fleischmann
Flores
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gaetz
Gallagher
Garrett
Gianforte
Gibbs
Gohmert
Goodlatte
Gosar
Gowdy
Granger
Graves (GA)
Graves (LA)
Griffith
Grothman
Guthrie
Handel
Harper
Harris
Hartzler
Hensarling
Herrera Beutler
Hice, Jody B.
Higgins (LA)
Hill
Holding
Hollingsworth
Hudson
Huizenga
Hultgren
Hunter
Hurd
Issa
Jenkins (KS)
Jenkins (WV)
Johnson (LA)
Johnson (OH)
Johnson, Sam
Jones
Jordan
Joyce (OH)
Katko
Kelly (MS)
Kelly (PA)
King (IA)
King (NY)
Kinzinger
Knight
Kustoff (TN)
Labrador
LaHood
LaMalfa
Lamborn
Lance
Latta
Lewis (MN)
LoBiondo
Long
Loudermilk
Love
Lucas
Luetkemeyer
MacArthur
Marchant
Marino
Marshall
Massie
Mast
McCarthy
McCaul
McClintock
McHenry
McKinley
McMorris Rodgers
McSally
Meehan
Messer
Mitchell
Moolenaar
Mooney (WV)
Mullin
Murphy (PA)
Newhouse
Noem
Norman
Nunes
Olson
Palazzo
Palmer
Paulsen
Pearce
Perry
Pittenger
Poe (TX)
Poliquin
Posey
Ratcliffe
Reed
Reichert
Rice (SC)
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rokita
Rooney, Francis
Rooney, Thomas J.
Ros-Lehtinen
Roskam
Ross
Rothfus
Rouzer
Royce (CA)
Russell
Rutherford
Sanford
Schweikert
Scott, Austin
Sensenbrenner
Sessions
Shimkus
Shuster
Simpson
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Smucker
Stefanik
Stewart
Stivers
Taylor
Tenney
Thompson (PA)
Thornberry
Tiberi
Tipton
Trott
Turner
Upton
Valadao
Wagner
Walberg
Walden
Walker
Walorski
Walters, Mimi
Weber (TX)
Webster (FL)
Wenstrup
Westerman
Williams
Wilson (SC)
Wittman
Womack
Woodall
Yoder
Yoho
Young (AK)
Young (IA)
Zeldin

NOES—188

Adams
Aguilar
Barragán
Beatty
Bera
Beyer
Bishop (GA)
Blumenauer
Blunt Rochester
Bonamici
Boyle, Brendan F.
Brady (PA)
Brown (MD)
Brownley (CA)
Bustos
Butterfield
Capuano
Carbajal
Cárdenas
Carson (IN)
Cartwright
Castor (FL)
Castro (TX)
Chu, Judy
Cicilline
Clark (MA)
Clarke (NY)
Clay
Cleaver
Clyburn
Cohen
Connolly
Conyers
Cooper
Correa
Costa
Courtney
Crist
Cuellar
Davis (CA)
DeFazio
DeGette
Delaney
DeLauro
DelBene
Demings
DeSaulnier
Deutch
Dingell
Doggett
Doyle, Michael F.
Ellison
Engel
Eshoo
Espaillat
Esty (CT)
Evans
Foster
Frankel (FL)
Fudge
Gabbard
Gallego
Garamendi
Gomez
Gonzalez (TX)
Gottheimer
Green, Gene
Grijalva
Gutiérrez
Hanabusa
Hastings
Heck
Higgins (NY)
Himes
Hoyer
Huffman
Jackson Lee
Jayapal
Jeffries
Johnson (GA)
Johnson, E. B.
Kaptur
Keating
Kelly (IL)
Kennedy
Khanna
Kihuen
Kildee
Kilmer
Kind
Krishnamoorthi
Kuster (NH)
Langevin
Larsen (WA)
Larson (CT)
Lawrence
Lawson (FL)
Lee
Levin
Lewis (GA)
Lieu, Ted
Lipinski
Loebsack
Lofgren
Lowenthal
Lowey
Lujan Grisham, M.
Luján, Ben Ray
Lynch
Maloney, Carolyn B.
Maloney, Sean
Matsui
McCollum
McEachin
McGovern
McNerney
Meeks
Meng
Moore
Moulton
Murphy (FL)
Nadler
Neal
Nolan
Norcross
O'Halleran
O'Rourke
Pallone
Panetta
Pascrell
Payne
Pelosi
Perlmutter
Peters
Peterson
Pingree
Pocan
Polis
Price (NC)
Quigley
Raskin
Rice (NY)
Richmond
Rosen
Roybal-Allard
Ruiz
Ruppersberger
Rush
Ryan (OH)
Sánchez
Sarbanes
Schakowsky
Schiff
Schneider
Schrader
Scott (VA)
Scott, David
Serrano
Sewell (AL)
Shea-Porter
Sherman
Sinema
Sires
Slaughter
Smith (WA)
Soto
Speier
Suozzi
Swalwell (CA)
Takano
Thompson (CA)
Thompson (MS)
Titus
Tonko
Torres
Tsongas
Vargas
Veasey
Vela
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters, Maxine
Watson Coleman
Welch
Wilson (FL)
Yarmuth

NOT VOTING—12

Bass
Brooks (AL)
Costello (PA)
Crowley
Cummings
Davis, Danny
Graves (MO)
Green, Al
Meadows
Napolitano
Renacci
Scalise

□ 1337

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

The House will resume proceedings on postponed questions at a later time.

MEDICARE PART B IMPROVEMENT ACT OF 2017

Mr. BRADY of Texas. Madam Speaker, I move to suspend the rules and pass the bill (H.R. 3178) to amend title XVIII of the Social Security Act to improve the delivery of home infusion therapy and dialysis and the application of the Stark rule under the Medicare program, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3178

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Part B Improvement Act of 2017''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—IMPROVEMENTS IN PROVISION OF HOME INFUSION THERAPY

Sec. 101. Home infusion therapy services temporary transitional payment.
Sec. 102. Extension of Medicare Patient IVIG Access Demonstration Project.
Sec. 103. Orthotist's and prosthetist's clinical notes as part of the patient's medical record.

TITLE II—IMPROVEMENTS IN DIALYSIS SERVICES

Sec. 201. Independent accreditation for dialysis facilities and assurance of high quality surveys.
Sec. 202. Expanding access to home dialysis therapy.

TITLE III—IMPROVEMENTS IN APPLICATION OF STARK RULE

Sec. 301. Modernizing the application of the Stark rule under Medicare.
Sec. 302. Funds from the Medicare Improvement Fund.

TITLE I—IMPROVEMENTS IN PROVISION OF HOME INFUSION THERAPY

SEC. 101. HOME INFUSION THERAPY SERVICES TEMPORARY TRANSITIONAL PAYMENT.

(a) IN GENERAL.—Section 1834(u) of the Social Security Act (42 U.S.C. 1395m(u)) is amended, by adding at the end the following new paragraph:

''(7) HOME INFUSION THERAPY SERVICES TEMPORARY TRANSITIONAL PAYMENT.—

''(A) TEMPORARY TRANSITIONAL PAYMENT.—

''(i) IN GENERAL.—The Secretary shall, in accordance with the payment methodology described in subparagraph (B) and subject to the provisions of this paragraph, provide a home infusion therapy services temporary transitional payment under this part to an eligible home infusion supplier (as defined in subparagraph (F)) for items and services described in subparagraphs (A) and (B) of section 1861(iii)(2)) furnished during the period specified in clause (ii) by such supplier in coordination with the furnishing of transitional home infusion drugs (as defined in clause (iii)).

''(ii) PERIOD SPECIFIED.—For purposes of clause (i), the period specified in this clause is the period beginning on January 1, 2019, and ending on the day before the date of the implementation of the payment system under paragraph (1)(A).

''(iii) TRANSITIONAL HOME INFUSION DRUG DEFINED.—For purposes of this paragraph, the term 'transitional home infusion drug' has the meaning given to the term 'home infusion drug' under section 1861(iii)(3)(C)), except that clause (ii) of such section shall not apply if a drug described in such clause is identified in clauses (i), (ii), (iii) or (iv) of subparagraph (C) as of the date of the enactment of this paragraph.

''(B) PAYMENT METHODOLOGY.—For purposes of this paragraph, the Secretary shall establish a payment methodology, with respect to items and services described in subparagraph (A)(i). Under such payment methodology the Secretary shall—

''(i) create the three payment categories described in clauses (i), (ii), and (iii) of subparagraph (C);

''(ii) assign drugs to such categories, in accordance with such clauses;

''(iii) assign appropriate Healthcare Common Procedure Coding System (HCPCS) codes to each payment category; and

''(iv) establish a single payment amount for each such payment category, in accordance with subparagraph (D), for each infusion drug administration calendar day in the individual's home for drugs assigned to such category.

''(C) PAYMENT CATEGORIES.—

''(i) PAYMENT CATEGORY 1.—The Secretary shall create a payment category 1 and assign to such category drugs which are covered under the Local Coverage Determination on External Infusion Pumps (LCD number L33794) and billed with the following HCPCS codes (as identified as of July 1, 2017, and as subsequently modified by the Secretary): J0133, J0285, J0287, J0288, J0289, J0895, J1170, J1250, J1265, J1325, J1455, J1457, J1570, J2175, J2260, J2270, J2274, J2278, J3010, or J3285.

''(ii) PAYMENT CATEGORY 2.—The Secretary shall create a payment category 2 and assign to such category drugs which are covered under such local coverage determination and billed with the following HCPCS codes (as identified as of July 1, 2017, and as subsequently modified by the Secretary): J1559 JB, J1561 JB, J1562 JB, J1569 JB, or J1575 JB.

''(iii) PAYMENT CATEGORY 3.—The Secretary shall create a payment category 3 and assign to such category drugs which are covered under such local coverage determination and billed with the following HCPCS codes (as identified as of July 1, 2017, and as subsequently modified by the Secretary): J9000, J9039, J9040, J9065, J9100, J9190, J9200, J9360, or J9370.

''(iv) INFUSION DRUGS NOT OTHERWISE INCLUDED.—With respect to drugs that are not included in payment category 1, 2, or 3 under clause (i), (ii), or (iii), respectively, the Secretary shall assign to the most appropriate of such categories, as determined by the Secretary, drugs which are—

''(I) covered under such local coverage determination and billed under HCPCS codes J7799 or J7999 (as identified as of July 1, 2017, and as subsequently modified by the Secretary); or

''(II) billed under any code that is implemented after the date of the enactment of this paragraph and included in such local coverage determination or included in subregulatory guidance as a home infusion drug described in subparagraph (A)(i).

''(D) PAYMENT AMOUNTS.—

''(i) IN GENERAL.—Under the payment methodology, the Secretary shall pay eligible home infusion suppliers, with respect to items and services described in subparagraph (A)(i) furnished during the period described in subparagraph (A)(ii) by such supplier to an individual, at amounts equal to the amounts determined under the physician fee schedule established under section 1848 for services furnished during the year for codes and units of such codes described in clauses (ii), (iii), and (iv) with respect to drugs included in the payment category under subparagraph (C) specified in the respective clause, determined without application of the geographic adjustment under subsection (e) of such section.

''(ii) PAYMENT AMOUNT FOR CATEGORY 1.—For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 1 described in subparagraph (C)(i), are one unit of HCPCS code 96365 plus four units of HCPCS code 96366 (as identified as of July 1, 2017, and as subsequently modified by the Secretary).

''(iii) PAYMENT AMOUNT FOR CATEGORY 2.—For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 2 described in subparagraph (C)(i), are one unit of HCPCS code 96369 plus four units of HCPCS code 96370 (as identified as of July 1, 2017, and as subsequently modified by the Secretary).

''(iv) PAYMENT AMOUNT FOR CATEGORY 3.—For purposes of clause (i), the codes and units described in this clause, with respect to drugs included in payment category 3 described in subparagraph (C)(i), are one unit of HCPCS code 96413 plus four units of HCPCS code 96415 (as identified as of July 1, 2017, and as subsequently modified by the Secretary).

''(E) CLARIFICATIONS.—

''(i) INFUSION DRUG ADMINISTRATION DAY.—For purposes of this subsection, a reference, with respect to the furnishing of transitional home infusion drugs or home infusion drugs to an individual by an eligible home infusion supplier, to payment to such supplier for an infusion drug administration calendar day in the individual's home shall refer to payment only for the date on which professional services (as described in section 1861(iii)(2)(A)) were furnished to administer such drugs to such individual. For purposes of the previous sentence, an infusion drug administration calendar day shall include all such drugs administered to such individual on such day.

''(ii) TREATMENT OF MULTIPLE DRUGS ADMINISTERED ON SAME INFUSION DRUG ADMINISTRATION DAY.—In the case that an eligible home infusion supplier, with respect to an infusion drug administration calendar day in an individual's home, furnishes to such individual transitional home infusion drugs which are not all assigned to the same payment category under subparagraph (C), payment to such supplier for such infusion drug administration calendar day in the individual's home shall be a single payment equal to the amount of payment under this paragraph for the drug, among all such drugs so furnished to such individual during such calendar day, for which the highest payment would be made under this paragraph.

''(F) ELIGIBLE HOME INFUSION SUPPLIERS.—In this paragraph, the term 'eligible home infusion supplier' means a supplier that is enrolled under this part as a pharmacy that provides external infusion pumps and external infusion pump supplies and that maintains all pharmacy licensure requirements in the State in which the applicable infusion drugs are administered.

''(G) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.''.

(b) CONFORMING AMENDMENT.—Section 1842(b)(6)(I) of the Social Security Act (42 U.S.C. 1395u(b)(6)(I)) is amended by inserting ''or, in the case of items and services described in clause (i) of section 1834(u)(7)(A) furnished to an individual during the period described in clause (ii) of such section, payment shall be made to the eligible home infusion therapy supplier'' after ''payment shall be made to the qualified home infusion therapy supplier''.

SEC. 102. EXTENSION OF MEDICARE PATIENT IVIG ACCESS DEMONSTRATION PROJECT.

Section 101(b) of the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 (42 U.S.C. 1395l note) is amended—

(1) in paragraph (1), by inserting after ''for a period of 3 years'' the following: ''and, subject to the availability of funds under subsection (g)—

''(A) if the date of enactment of the Medicare Part B Improvement Act of 2017 is on or before September 30, 2017, for the period beginning on October 1, 2017, and ending on December 31, 2020; and

''(B) if the date of enactment of such Act is after September 30, 2017, for the period beginning on the date of enactment of such Act and ending on December 31, 2020'' ''; and

(2) in paragraph (2), by adding at the end the following new sentences: ''Subject to the preceding sentence, a Medicare beneficiary enrolled in the demonstration project on September 30, 2017, shall be automatically enrolled during the period beginning on the date of the enactment of the Medicare Part B Improvement Act of 2017 and ending on December 31, 2020, without submission of another application. Chapter 35 of title 44, United States Code, shall not apply to any application form used for a Medicare beneficiary who enrolls in the demonstration project on or after such date of enactment.''.

SEC. 103. ORTHOTIST'S AND PROSTHETIST'S CLINICAL NOTES AS PART OF THE PATIENT'S MEDICAL RECORD.

Section 1834(h) of the Social Security Act (42 U.S.C. 1395m(h)) is amended by adding at the end the following new paragraph:

''(5) DOCUMENTATION CREATED BY ORTHOTISTS AND PROSTHETISTS.—For purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by an orthotist or prosthetist shall be considered part of the individual's medical record to support documentation created by eligible professionals described in section 1848(k)(3)(B).''.

TITLE II—IMPROVEMENTS IN DIALYSIS SERVICES

SEC. 201. INDEPENDENT ACCREDITATION FOR DIALYSIS FACILITIES AND ASSURANCE OF HIGH QUALITY SURVEYS.

(a) ACCREDITATION AND SURVEYS.—

(1) IN GENERAL.—Section 1865 of the Social Security Act (42 U.S.C. 1395bb) is amended—

(A) in subsection (a)—

(i) in paragraph (1), in the matter preceding subparagraph (A), by striking ''or the conditions and requirements under section 1881(b)''; and

(ii) in paragraph (4), by inserting ''(including a renal dialysis facility)'' after ''facility''; and

(B) by adding at the end the following new subsection:

''(e) With respect to an accreditation body that has received approval from the Secretary under subsection (a)(3)(A) for accreditation of provider entities that are required to meet the conditions and requirements under section 1881(b), in addition to review and oversight authorities otherwise applicable under this title, the Secretary shall (as the Secretary determines appropriate) conduct, with respect to such accreditation body and provider entities, any or all of the following as frequently as is otherwise required to be conducted under this title with respect to other accreditation bodies or other provider entities:

''(1) Validation surveys referred to in subsection (d).

''(2) Accreditation program reviews (as defined in section 488.8(c) of title 42 of the Code of Federal Regulations, or a successor regulation).

''(3) Performance reviews (as defined in section 488.8(a) of title 42 of the Code of Federal Regulations, or a successor regulation).''.

(2) TIMING FOR ACCEPTANCE OF REQUESTS FROM ACCREDITATION ORGANIZATIONS.—Not

later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall begin accepting requests from national accreditation bodies for a finding described in section 1865(a)(3)(A) of the Social Security Act (42 U.S.C. 1395bb(a)(3)(A)) for purposes of accrediting provider entities that are required to meet the conditions and requirements under section 1881(b) of such Act (42 U.S.C. 1395rr(b)).

(b) REQUIREMENT FOR TIMING OF SURVEYS OF NEW DIALYSIS FACILITIES.—Section 1881(b)(1) of the Social Security Act (42 U.S.C. 1395rr(b)(1)) is amended by adding at the end the following new sentence: ''Beginning 180 days after the date of the enactment of this sentence, an initial survey of a provider of services or a renal dialysis facility to determine if the conditions and requirements under this paragraph are met shall be initiated not later than 90 days after such date on which both the provider enrollment form (without regard to whether such form is submitted prior to or after such date of enactment) has been determined by the Secretary to be complete and the provider's enrollment status indicates approval is pending the results of such survey.''.

SEC. 202. EXPANDING ACCESS TO HOME DIALYSIS THERAPY.

(a) ALLOWING USE OF TELEHEALTH FOR MONTHLY END STAGE RENAL DISEASE-RELATED VISITS.—

(1) IN GENERAL.—Paragraph (3) of section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) is amended—

(A) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;

(B) in clause (i), as redesignated by subparagraph (A), by striking ''under this subparagraph'' and inserting ''under this clause'';

(C) in clause (ii), as redesignated by subparagraph (A), by inserting ''subject to subparagraph (B),'' before ''on a comprehensive'';

(D) by striking ''With respect to'' and inserting ''(A) With respect to''; and

(E) by adding at the end the following new subparagraph:

''(B)(i) Subject to clause (ii), an individual who is determined to have end stage renal disease and who is receiving home dialysis may choose to receive monthly end stage renal disease-related visits, furnished on or after January 1, 2019, via telehealth.

''(ii) Clause (i) shall apply to an individual only if the individual receives a face-to-face visit, without the use of telehealth—

''(I) in the case of the initial three months of home dialysis of such individual, at least monthly; and

''(II) after such initial three months, at least once every three consecutive months.''.

(2) CONFORMING AMENDMENT.—Paragraph (1) of such section is amended by striking ''paragraph (3)(A)'' and inserting ''paragraph (3)(A)(i)''.

(b) EXPANDING ORIGINATING SITES FOR TELEHEALTH TO INCLUDE RENAL DIALYSIS FACILITIES AND THE HOME FOR PURPOSES OF MONTHLY END STAGE RENAL DISEASE-RELATED VISITS.—

(1) IN GENERAL.—Section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)) is amended—

(A) in paragraph (4)(C)(ii), by adding at the end the following new subclauses:

''(IX) A renal dialysis facility, but only for purposes of section 1881(b)(3)(B).

''(X) The home of an individual, but only for purposes of section 1881(b)(3)(B).''; and

(B) by adding at the end the following new paragraph:

''(5) TREATMENT OF HOME DIALYSIS MONTHLY ESRD-RELATED VISIT.—The geographic requirements described in paragraph (4)(C)(i) shall not apply with respect to telehealth services furnished on or after January 1, 2019, for purposes of section 1881(b)(3)(B), at an originating site described in subclause (VI), (IX), or (X) of paragraph (4)(C)(ii)), subject to applicable State law requirements, including State licensure requirements.''.

(2) NO FACILITY FEE IF ORIGINATING SITE FOR HOME DIALYSIS THERAPY IS THE HOME.—Section 1834(m)(2)(B) of the Social Security (42 U.S.C. 1395m(m)(2)(B)) is amended—

(A) by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively, and by indenting each of such subclauses 2 ems to the right;

(B) in subclause (II), as redesignated by subparagraph (A), by striking ''clause (i) or this clause'' and inserting ''subclause (I) or this subclause'';

(C) by striking ''SITE.—With respect to'' and inserting ''SITE.—

''(i) IN GENERAL.—Subject to clause (ii), with respect to''; and

(D) by adding at the end the following new clause:

''(ii) NO FACILITY FEE IF ORIGINATING SITE FOR HOME DIALYSIS THERAPY IS THE HOME.—No facility fee shall be paid under this subparagraph to an originating site described in subclause (X) of paragraph (4)(C)(ii).''.

(c) CLARIFICATION REGARDING TELEHEALTH PROVIDED TO BENEFICIARIES.—Section 1128A(i)(6) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) in subparagraph (H), by striking ''; or'' and inserting a semicolon;

(2) in subparagraph (I), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following new subparagraph:

''(J) the provision of telehealth technologies on or after January 1, 2019, to individuals with end stage renal disease under title XVIII by a health care provider for the purpose of furnishing of telehealth.''.

(d) STUDY AND REPORT ON FURTHER EXPANSION.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to examine the feasibility, benefits, and drawbacks of expanding the use of telehealth and store-and-forward technologies under the Medicare program under title XVIII of the Social Security Act for items and services included in renal dialysis services, as such term is defined in section 1881(b)(14)(B) of such Act (42 U.S.C. 1395rr(b)(14)(B)).

(2) REPORT.—Not later than two years after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the results of the study conducted under paragraph (1).

TITLE III—IMPROVEMENTS IN APPLICATION OF STARK RULE

SEC. 301. MODERNIZING THE APPLICATION OF THE STARK RULE UNDER MEDICARE.

(a) CLARIFICATION OF THE WRITING REQUIREMENT AND SIGNATURE REQUIREMENT FOR ARRANGEMENTS PURSUANT TO THE STARK RULE.—

(1) WRITING REQUIREMENT.—Section 1877(h)(1) of the Social Security Act (42 U.S.C. 1395nn(h)(1)) is amended by adding at the end the following new subparagraph:

''(D) WRITTEN REQUIREMENT CLARIFIED.—In the case of any requirement pursuant to this section for a compensation arrangement to be in writing, such requirement shall be satisfied by such means as determined by the Secretary, including by a collection of documents, including contemporaneous documents evidencing the course of conduct between the parties involved.''.

(2) SIGNATURE REQUIREMENT.—Section 1877(h)(1) of the Social Security Act (42 U.S.C. 1395nn(h)(1)), as amended by paragraph (1), is further amended by adding at the end the following new subparagraph:

''(E) SPECIAL RULE FOR SIGNATURE REQUIREMENTS.—In the case of any requirement pursuant to this section for a compensation arrangement to be in writing and signed by the parties, such signature requirement shall be met if—

''(i) not later than 90 consecutive calendar days immediately following the date on which the compensation arrangement became noncompliant, the parties obtain the required signatures; and

''(ii) the compensation arrangement otherwise complies with all criteria of the applicable exception.''.

(b) INDEFINITE HOLDOVER FOR LEASE ARRANGEMENTS AND PERSONAL SERVICES ARRANGEMENTS PURSUANT TO THE STARK RULE.—Section 1877(e) of the Social Security Act (42 U.S.C. 1395nn(e)) is amended—

(1) in paragraph (1), by adding at the end the following new subparagraph:

''(C) HOLDOVER LEASE ARRANGEMENTS.—In the case of a holdover lease arrangement for the lease of office space or equipment, which immediately follows a lease arrangement described in subparagraph (A) for the use of such office space or subparagraph (B) for the use of such equipment and that expired after a term of at least one year, payments made by the lessee to the lessor pursuant to such holdover lease arrangement, if—

''(i) the lease arrangement met the conditions of subparagraph (A) for the lease of office space or subparagraph (B) for the use of equipment when the arrangement expired;

''(ii) the holdover lease arrangement is on the same terms and conditions as the immediately preceding arrangement; and

''(iii) the holdover arrangement continues to satisfy the conditions of subparagraph (A) for the lease of office space or subparagraph (B) for the use of equipment.''; and

(2) in paragraph (3), by adding at the end the following new subparagraph:

''(C) HOLDOVER PERSONAL SERVICE ARRANGEMENT.—In the case of a holdover personal service arrangement, which immediately follows an arrangement described in subparagraph (A) that expired after a term of at least one year, remuneration from an entity pursuant to such holdover personal service arrangement, if—

''(i) the personal service arrangement met the conditions of subparagraph (A) when the arrangement expired;

''(ii) the holdover personal service arrangement is on the same terms and conditions as the immediately preceding arrangement; and

''(iii) the holdover arrangement continues to satisfy the conditions of subparagraph (A).''.

SEC. 302. FUNDS FROM THE MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1) of the Social Security Act (42 U.S.C. 1395iii(b)(1)) is amended by striking ''during and after fiscal year 2021, $270,000,000'' and inserting ''during and after fiscal year 2021, $245,000,000''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. BRADY) and the gentleman from Massachusetts (Mr. NEAL) each will control 20 minutes.

The Chair recognizes the gentleman from Texas.

GENERAL LEAVE

Mr. BRADY of Texas. Madam Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 3178, currently under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. BRADY of Texas. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, improving and strengthening Medicare for the long term is a major priority for the American people and Members of Congress on both sides of the aisle; but as we pursue this larger goal, we should not pass up opportunities to make smart, focused improvements that will help Medicare beneficiaries today. That is exactly what the Medicare Part B Improvement Act will do.

I introduced this bill with Ways and Means Ranking Member RICHARD NEAL, Health Subcommittee Chairman PAT TIBERI, and Ranking Member SANDER LEVIN. This legislation delivers targeted, immediate reforms to make Medicare work better for the American people, and it includes solutions from roughly one dozen Members of Congress on both sides of the aisle.

The Medicare Part B Improvement Act takes action on three primary goals: first, expanding access to high-quality care; second, improving efficiency in the delivery of care so that patients can better receive the care they need when they need it; and, third, easing administrative burdens on healthcare providers so they can spend less time on paperwork and more time with patients.

Importantly, H.R. 3178 extends and improves Medicare home infusion services, which allow patients to receive personalized care in the comfort of their own home.

This legislation also extends an ongoing Medicare pilot program, the IVIG demonstration program, that allows patients with weakened immune systems to receive care in their homes.

This demonstration program carries a lot of meaning for me. I introduced it in 2012 as a direct response to the challenges facing patients with immunodeficiency diseases.

□ 1345

As I learned from Carol Ann Demaret, a constituent and friend of mine whose son David suffered from severe combined immunodeficiency disease, life with a severely weakened immune system can be an incredible struggle. For children especially, it can be a daily fight just to survive.

Allowing these vulnerable patients to receive treatment from the safety of their own home cannot only improve the quality of care, it can greatly enhance their quality of life. It can give a kid a real chance to be a kid.

In addition to these important provisions, this bill contains numerous solutions that will lower healthcare costs and increase access to high-quality, coordinated care for beneficiaries.

More than that, the bill is an excellent example of what we can accomplish through regular order. This legislation was approved unanimously by the Ways and Means Committee on July 13. It demonstrates how, working together, we can solve real challenges facing patients, families, and healthcare providers in our communities.

I would like to thank all the Ways and Means members on both sides of the aisle who helped craft the solutions in this bill. I would also like to recognize Chairman WALDEN and Ranking Member PALLONE of the Energy and Commerce Committee for their leadership and hard work in helping us move this bill forward.

The Medicare Part B Improvement Act takes targeted action to make Medicare work better for the American people. I urge all of my colleagues to join me in supporting its passage.

Madam Speaker, I reserve the balance of my time, and I ask unanimous consent that the gentleman from Ohio (Mr. TIBERI), chairman of the Health Subcommittee, be permitted to control the remainder of the time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. NEAL. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I stand in support of H.R. 3178, the Medicare Part B Improvement Act of 2017.

I am pleased that Chairman BRADY, along with Health Subcommittee Chairman TIBERI, Ranking Member LEVIN, and I worked in a bipartisan manner to draft this legislation. It brings together a number of important measures to improve Medicare part B. I encourage all of our colleagues to support it.

As I said during the bipartisan Ways and Means Committee markup of H.R. 3178, I hope the committee will be able to hold more meetings like this. This is what the American people want and expect from their Members: to get things done in a bipartisan manner.

The bill before us today is pretty straightforward. It makes important changes to Medicare part B in a number of ways. It includes a commonsense transitional policy for home infusion services, cosponsored by Mr. TIBERI and Mr. PASCRELL.

Our colleagues Mr. BISHOP and Mr. MIKE THOMPSON are cosponsors of language to streamline Medicare rules to improve access to medically necessary prosthetics and orthotics.

Mr. JOHN LEWIS cosponsored language to help dialysis facilities improve backlogs so they can more efficiently treat end-stage renal disease.

Ms. DELBENE and Mr. MIKE THOMPSON are cosponsors of a bill that allows telehealth so patients can receive dialysis in the comfort of their own home.

Finally, the measure includes clarification language to Stark laws that Mr. KIND led to provide more certainty for Medicare providers.

Our colleagues on both sides of the aisle worked hard on these bills, and I am pleased we can move them forward in a bipartisan manner.

Madam Speaker, I encourage my colleagues to support H.R. 3178, and I reserve the balance of my time.

Mr. TIBERI. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, I stand in this Chamber today in strong support of H.R. 3178, a package of bipartisan policies centered on improving care for Medicare beneficiaries across several areas.

In particular, H.R. 3178 includes a bill that I introduced with my friend and colleague from New Jersey, Mr. BILL PASCRELL, that provides a temporary transitional payment for home infusion providers.

The 21st Century Cures Act created a new reimbursement benefit for home infusion therapies beginning in 2021. This new temporary transitional payment will bridge the potential gap in care for beneficiaries, and home infusion providers will continue to administer these therapies without going bankrupt.

This legislation includes other good public policies that further encourage giving seniors the choice to receive more care in the comfort of their own homes, as well as expanding access to providers, particularly in rural and in needy areas.

I would like to thank my colleagues on the Ways and Means Committee for their support. I would also like to thank my colleagues on the Energy and Commerce Committee for their commitment to working on this issue, especially MICHAEL BURGESS, as well as Chairman Emeritus FRED UPTON, who helped pave the way for these policies with the passage of the 21st Century Cures Act.

Madam Speaker, I would like to conclude with a commitment that this is not an end for policies encouraging care—especially drug infusion—in the home for patients who choose to do so. We look forward to working with the administration and clarifying current rules to ensure we successfully implement both this legislation and future policies to ensure inclusion of payment for all drugs needed by the home infusion patient community.

Madam Speaker, I reserve the balance of my time.

Mr. NEAL. Madam Speaker, I yield 3 minutes to the gentleman from California (Mr. THOMPSON).

Mr. THOMPSON of California. Madam Speaker, I thank the gentleman for yielding.

Madam Speaker, I rise in strong support of this legislation, and I want to thank all my colleagues who worked in a bipartisan manner to make it happen.

Patients and providers in my district and across the country will benefit from these important improvements, and I am proud to support them.

Two provisions come from bipartisan bills that I have worked on for a number of years. The first helps patients get the devices they need while keeping fraudulent providers out of Medicare. The change we are debating today

will ensure that any documentation created by device experts will be included in a patient's medical record to support the physician's directions.

The second provision that I authored comes from the comprehensive telehealth packages that I have been working on with Representative BLACK and our colleagues from the Energy and Commerce Committee, Mr. WELCH and Mr. HARPER. This change will allow for virtual visits and remote patient monitoring for kidney failure patients living at home. Letting these patients utilize telehealth ensures that they can access the services they need from the setting that they prefer: their homes.

This bill is another step forward in the expansion of telehealth, but we can do a lot more. Our telehealth bills offer a menu of options for moving forward. Policies like paying for telestroke services or adding telehealth to the Medicare Advantage program have bipartisan support among both Houses, as well as a broad coalition of support from stakeholders.

We know they save money. I have worked on telehealth for decades. When I was in the California State Senate, I wrote the State's first telehealth legislation to bring critical services to folks enrolled in the State Medicaid program. That was in 1996. Now it is 2017, and we still haven't passed, in Congress, comprehensive telehealth legislation that would expand access for Medicare beneficiaries.

It is long past time for Congress to come to the conclusion that California reached long ago: telehealth saves money, and it saves lives. I am optimistic that the passage of this bill is just a small sample of what is to come in regard to telehealth in the future.

Mr. TIBERI. Madam Speaker, I yield 2 minutes to the gentleman from Texas (Mr. BURGESS), chairman of the Health Subcommittee of the Energy and Commerce Committee and a leader on healthcare issues.

Mr. BURGESS. Madam Speaker, I thank the gentleman for yielding.

Madam Speaker, I rise in support of H.R. 3178, the Medicare Part B Improvement Act of 2017.

This bill represents a series of bipartisan reforms from the Committees on Energy and Commerce and Ways and Means that will provide targeted reforms to improve access to care for Medicare beneficiaries.

Home infusion patients are oftentimes our Nation's sickest and most vulnerable, and maintaining access to these services in home settings has proved invaluable in ensuring that patients can continue to effectively receive the care that they need.

Under last year's 21st Century Cures Act, we took the necessary steps to ensure that taxpayers and beneficiaries were no longer overcharged on the acquisition and dispensing costs associated with home infusion. Additionally, we took complementary steps to recognize the unique education needs associated with receiving infusion in the home.

However, as my subcommittee learned in a hearing on this issue just last week, there is still more that must be done to integrate these two policies without jeopardizing access to patient care. Therefore, today's bill creates a bridge to connect these critical policies and to resolve the issue.

Additionally, H.R. 3178 takes an additional needed step to protect home health services by expanding opportunities for individuals to receive home dialysis. Access to services like home infusion and home dialysis has had a significant impact in my home State of Texas, and I am encouraged by today's bill, as it will build upon these additional successes for Texans and all Americans.

I would like to thank Chairman BRADY, Chairman TIBERI, and Chairman WALDEN for their leadership on the bill. They rose to the challenge to address these tough policy decisions. This bill is a product of their hard work, as well as the hard work of all the staff involved at the subcommittee and full committee level, and I thank them as well.

Mr. NEAL. Madam Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. PASCRELL).

Mr. PASCRELL. Madam Speaker, I rise today in support of H.R. 3178, the Medicare Part B Improvement Act.

I am pleased that the bill before us today includes legislation that I introduced with my good friend PAT TIBERI from Ohio, the Medicare Part B Home Infusion Services Temporary Transitional Payment Act.

Listening to Mr. TIBERI and Mr. NEAL, I believe what they say should resonate across the Hill. This can't be one and done. Bipartisanship is something that should be contagious, particularly as we are talking about a healthcare event which is important and may mean life or death to many of our citizens.

Home infusion is an essential treatment option for individuals suffering from many, many debilitating diseases like cancer, congestive heart failure, multiple sclerosis, and rheumatoid arthritis. The 21st Century Cures Act, which became law last year, correctly adjusted payments for home infusion drugs and would establish a new home infusion nursing benefit within Medicare beginning in 2021.

However, we have heard concerns that the payment adjustment going into effect before the nursing benefit is implemented could jeopardize access to home infusion in the interim. The bill that Congressman TIBERI from Ohio and I introduced would address that concern by creating a temporary nursing benefit until the new permanent benefit can be implemented.

Madam Speaker, I urge my colleagues to support H.R. 3178.

Mr. TIBERI. Madam Speaker, I yield 2 minutes to the gentlewoman from Kansas (Ms. JENKINS), a valuable member of our Health Subcommittee of the Ways and Means Committee.

Ms. JENKINS of Kansas. Madam Speaker, I rise today in support of H.R. 3178, the Medicare Part B Improvement Act of 2017, which includes my legislation, the Dialysis Certification Act.

Kansas currently ranks among the top three longest wait times for dialysis center surveys. The lack of manpower at the State administrative agency that contracts with CMS for these surveys has left some clinics waiting 2 years for a certification. This bill gives dialysis providers the opportunity to receive surveys and certifications from a CMS-approved third-party accreditor, much like hospitals are able to do now.

□ 1400

Those third-party organizations must demonstrate their standards are as good as or better than the standards used by CMS, and the Secretary must approve them.

I toured several clinics in my district last year, and I was frustrated to learn that a state-of-the-art clinic, necessary to fill a need in Topeka for ESRD patients, has been waiting 2 years for an initial survey, and a clinic in Pittsburg, Kansas, has been waiting for 250 days. Without these clinics, patients are forced to find clinics much further away, which, depending on the access to transportation, can be a barrier to treatment. That is unacceptable, and this problem will be easily solved by this provision.

I want to thank my cosponsor, Congressman JOHN LEWIS, the Energy and Commerce Committee and the Ways and Means Committee chairmen for quickly moving this bill to the House floor for action. This provision will allow dialysis clinics across America to more easily obtain a survey so they may serve patients that depend on their care.

Mr. NEAL. Madam Speaker, I yield 2 minutes to the gentlewoman from Washington (Ms. DELBENE), who is a coauthor of this legislation.

Ms. DELBENE. Madam Speaker, I would like to thank the chair and the ranking member for working with me to include a proposal in this bill that I developed with Congresswoman BLACK, Congressman THOMPSON, and Congressman MEEHAN modernizing Medicare and harnessing the promise of telehealth to improve care for patients nationwide.

Allowing patients with end-stage renal disease to receive dialysis at home can dramatically improve their health outcomes and quality of life. This is something I have heard consistently from providers in my home State of Washington, like the Northwest Kidney Centers, who do incredible work to help patients receive dialysis at home when it is medically appropriate.

Advances in telehealth hold great potential to extend this treatment option to more Americans, particularly in rural communities, but there are still too many barriers to the use of cutting-edge technologies in Medicare.

There is a great need to update our laws to reflect these innovations and reimburse telehealth appropriately; otherwise, we won't just be denying access to healthcare today, we could be preventing the next frontier of innovations from even getting off the ground.

Without the long-term visibility of Medicare coverage, startups and entrepreneurs might never get the funding they need to develop new technologies and bring them to market. It is essential that we unlock the full potential of telehealth. By doing so, we can improve patient care, promote health, defeat heartbreaking diseases, and save lives. That is why I am so glad we are taking this step today.

Thank you again to the committee for working with me on this important bill, and I hope it is the first of many victories as we work together to expand telehealth.

I urge my colleagues to vote ''yes.''

Mr. TIBERI. Mr. Speaker, I yield 2 minutes to the gentlewoman from Tennessee (Mrs. BLACK), a valuable member of the Health Subcommittee of the Committee on Ways and Means and who, as you have already heard from previous speakers, has an important provision in this bill and who, more importantly, brings her valuable training as a nurse who practiced before she came to Congress.

Mrs. BLACK. Mr. Speaker, I thank my colleague for yielding me time on this very important issue.

I also want to thank my colleagues for working with me on this—Mr. MEEHAN, Mr. THOMPSON, and Ms. DELBENE—for working on a really important piece of legislation that is included in this package, which will improve the quality of life for seniors on Medicare across the country.

As has previously been said, I am a nurse. I have worked in the field for over 45 years, and I am proud to sponsor a bill that enhances patient care for those patients who are suffering from end-stage renal disease.

You know, we have made tremendous advances in technology over the last decade, and now it would be almost something we couldn't have thought of 45 years ago. Physicians can remotely monitor patients in their dialysis treatments through telehealth to reduce the number of medical visits that are necessary, to ensure that the treatment is efficient and effective, and to also catch signs of complications early, which would cause not only a decrease in quality of care for the patient, but also a cost.

Telehealth provides patients an important component in the comfort of their own homes—think about being sick and having to get in the car to travel—while physicians now have a new tool to treat their patients' whole health.

Our seniors deserve access to this innovative care, and it can save money. It can help to ensure that Medicare can be there for seniors who most need the care.

So I urge my colleagues to take a vote for your constituents and for Medicare beneficiaries across the country and support this bill.

I also look forward to continuing this work. This is certainly not the end of what we can do for our patients who are homebound and need care in the home. I will continue this work with Members on both sides of the aisle, which is being done now, for our Nation's seniors to have access to these kinds of innovative telehealth technologies that will improve care and also, more importantly, help to lower the cost of treatment.

I urge passage of this amendment.

Mr. NEAL. Mr. Speaker, I yield 1 minute to the gentlewoman from California (Ms. MATSUI), whose husband served with great distinction as a member of the Ways and Means Committee.

Ms. MATSUI. Mr. Speaker, I rise today in support of H.R. 3178, the Medicare Part B Improvement Act, and, specifically, a provision to extend the IVIG demonstration project that Chairman BRADY and I worked on together.

I have long been a champion of those impacted by primary immunodeficiency diseases, which include more than 300 rare genetic diseases, all of which keep the immune system from functioning properly. A mild infection can cause serious problems and even death for these patients.

Thanks to the IVIG demo, Medicare beneficiaries with immunodeficiency diseases are now able to receive in-home IVIG therapy, meaning they can avoid community settings of care, which can be very important to people with compromised immune systems.

I am pleased that this provision was included in the Medicare Part B Improvement Act. I urge support of this important bill.

Mr. TIBERI. Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield 4 minutes to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. Mr. Speaker, as so often happens here, this bill bears a somewhat grander title than its contents. Medicare part B certainly does need improvement. While I support putting into statute what is already administrative practice, extending a demonstration project that appears to be working and the other provisions that my colleagues have worked on in this bill, I think much more should have happened.

It is especially ironic that, at the very moment we are considering this bill, the United States Senate across the hall is proposing to eliminate healthcare coverage for millions of Americans. Certainly, this Republican repeal effort does far more harm to far more people than we can collectively undo here in the House with this rather modest piece of legislation.

And there is one glaring omission from today's Medicare Improvement Act, one subject that the Republican leadership of the House Ways and Means Committee fears. It fears not only doing something about this problem, it fears about even understanding the extent of the problem, and it certainly fears having any public hearings to explore this subject. That is the menace that is affecting millions of people across this country: pharmaceutical price gouging.

This bill fails to address any aspect of soaring pharmaceutical costs of part B medications. For almost a year, a number of us, House Democrats on the Ways and Means Committee, have called on the chairman to at least schedule a hearing about all aspects, all categories of soaring pharmaceutical prices that not only mean financial ruin for too many families, but also burden Medicare and most any type of taxpayer-financed healthcare initiative.

Government-approved monopolies for drug manufacturers are being exploited by charging the sick and dying whatever they might pay for a little more life, for a little more comfort at monopoly prices.

Under longstanding existing law—it has been there before this Congress ever got together—pharmaceutical companies are at least required to provide average sales price data on part B Medicare drugs. Three years ago, the Office of the Inspector General at the Department of Health and Human Services found that at least one-third of the more than 200 manufacturers of part B drugs had not submitted any of this average sales price data for some of their products, and an additional 45 manufacturers had not been required to report any data. The Inspector General found that inaccuracies in these average sales price filings may affect taxpayer-financed Medicare payments.

Last month, the nonpartisan Medicare Payment Advisory Commission came before the House Ways and Means Committee and gave its report on Medicare. It noted that this problem on average sales price data continues, and that it has not been addressed by Congress, as the Inspector General had recommended.

The Republican majority has refused to do anything about this problem. It has blocked an amendment that I offered in committee that simply implemented the recommendation of the Inspector General and of MedPAC to get that average sales price data and to ensure that all part B manufacturers report that data or are penalized at a reasonable level. It would simply have ensured compliance with existing law to protect program integrity and to protect the taxpayer interest. And you can be sure that if the Republicans didn't want to know what the prices were, they certainly didn't want to do anything about the soaring prices and the impact on American families.

So I support the bill, but this is a missed opportunity that we should have employed to address a critical problem.

Mr. TIBERI. Mr. Speaker, I yield myself as much time as I may consume.

As the previous speaker said, he supports the bill, which I am pleased to hear that, but as the chairman has said, as the ranking member has said, this is just the beginning. This is just the beginning, and we can't let the perfect be the enemy of the good in this piece of legislation because there is very important bipartisan legislation that is meaningful to people in a home today somewhere in Ohio or Massachusetts where home infusion is really important or dialysis is really important.

I am pleased that the ranking member from Massachusetts has been so helpful on this bill, and I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I want to thank the staff for their hard work on this bill, including Amy Hall, Sarah Levin, Melanie Egorin from the Democratic staff; Emily Murry and Nick Uehlecke from the Republican staff; Jessica Shapiro from the House Legislative Counsel's office; Ira Burney, Jennifer Druckman, and Lisa Yen from CMS; and the staff of the Congressional Budget Office, Tom Bradley, Rebecca Yip, and Lara Robillard. I want to thank them all for their very, very hard work.

We have this rare opportunity, this rare moment where we have broad agreement on this legislation, and I hope all Members of the House can find their way to be supportive of this legislation, and I hope the path of bipartisanship that we have chosen here can serve as a reminder of what we can get done.

Mr. Speaker, I yield back the balance of my time.

Mr. TIBERI. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I just say ''ditto'' to the gentleman from Massachusetts (Mr. NEAL), whom I have a great relationship with, for all the words about the staff. In particular, I also want to thank Abby Finn from my staff, and Emily Murray and her team; but it has been a pleasure working with the gentleman from Massachusetts' team as well, and Mr. LEVIN, the ranking member of the Health Subcommittee.

Mr. Speaker, this is a good step in the right direction and the first step in expanding access to high-quality care and improving efficiency and delivery of care so seniors can better receive the care they need where they need it, which is so incredibly important. I really appreciate the comments of the ranking member.

And again, I want to remind everybody what the chairman said, that this is just the beginning, and hopefully this will be a template to much more bipartisan support for the remainder of this year.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. SIMPSON). The question is on the motion offered by the gentleman from Texas (Mr. BRADY) that the House suspend the rules and pass the bill, H.R. 3178, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

□ 1415

PLUM ISLAND PRESERVATION ACT

Mr. DONOVAN. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 2182) to require the Comptroller General of the United States to submit a report to Congress on the alternatives for the final disposition of Plum Island, including preservation of the island for conservation, education, and research, and for other purposes.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 2182

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Plum Island Preservation Act''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) The Federal Government has owned Plum Island, New York, since 1899.

(2) Since 1954, the Plum Island Animal Disease Center has conducted unrivaled scientific research on a variety of infectious animal-borne diseases, including foot-and-mouth disease, resulting, most recently, in the development of a new cell line that rapidly and reliably detects this highly debilitating disease of livestock.

(3) Over 62 years, the Center has had a strong, proven record of safety.

(4) $23,200,000 in Federal dollars have been spent on upgrades to, and the maintenance of, the Center since January 2012.

(5) In addition to the Center, Plum Island contains cultural, historical, ecological, and natural resources of regional and national significance.

(6) Plum Island is situated where the Long Island Sound and Peconic Bay meet, both of which are estuaries that are part of the National Estuary Program and are environmentally and economically significant to the region.

(7) The Federal Government has invested hundreds of millions of Federal dollars over the last two decades to make long-term improvements with respect to the conservation and management needs of Long Island Sound and Peconic Bay.

(8) In a report submitted to Congress on April 11, 2016, entitled ''National Bio- and Agro-Defense Facility Construction Plan Update'' the Department of Homeland Security noted that the new National Bio- and Agro-Defense Facility under construction on such date in Manhattan, Kansas, is, as of such date, fully paid for through a combination of Federal appropriations and funding from the State of Kansas.

SEC. 3. REPORT REQUIRED ON FINAL DISPOSITION OF PLUM ISLAND.

Not later than one year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report containing the following:

(1) The alternatives for the final disposition of Plum Island, including the transfer of ownership to another Federal agency, a State or local government, a nonprofit organization, or a combination thereof for the purpose of education, research, or conservation.

(2) With respect to each such alternative final disposition, an analysis of—

(A) the effect such disposition would have on the island's resources;

(B) the remediation responsibilities under such disposition;

(C) any future legislation necessary to implement such disposition;

(D) the possible implications and issues, if any, of implementing such disposition;

(E) the costs of such disposition, including any potential costs related to the transition, hazard mitigation, and cleanup of property that would be incurred by a recipient of the property under such disposition; and

(F) the potential revenue from such disposition.

SEC. 4. SUSPENSION OF ACTION.

No action, including any pre-sale marketing activity, may be taken to carry out section 538 of title V of division D of the Consolidated Appropriations Act, 2012 (Public Law 112–74; 125 Stat. 976) until at least 180 days after the report required by section 3 has been submitted to Congress.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New York (Mr. DONOVAN) and the gentleman from New Jersey (Mr. PAYNE) each will control 20 minutes.

The Chair recognizes the gentleman from New York.

GENERAL LEAVE

Mr. DONOVAN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and include any extraneous material on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

Mr. DONOVAN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H.R. 2182, the Plum Island Preservation Act, sponsored by my colleague from New York (Mr. ZELDIN).

This bill requires the Government Accountability Office to review the alternatives for the final disposition of the Department of Homeland Security's Science and Technology Directorate's Plum Island Animal Disease Center, commonly known as Plum Island.

Since 1954, Plum Island, located in Suffolk County, New York, has served the Nation in defending against accidental or intentional introduction of foreign animal diseases, including foot-and-mouth disease. However, Plum Island's facilities are aging and nearing the end of their life cycle.

That is why in 2005, DHS announced that the work being conducted on Plum Island would be moved to a new Federal facility in Kansas. Plum Island will continue to operate until the National Bio and Agro-Defense Facility is fully operational and a complete transition has been made in 2022 or 2023.

This raises the question of what will happen to Plum Island once its activities are fully transferred over to the